Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS SPINE AND SURGICAL HOSPITAL
18600 N HARDY OAK BLVD
SAN ANTONIO TX 78258

Respondent Name
Hartford Underwriters Insurance

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-13-0292-01

MFDR Date Received
September 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Maximum Allowable Reimbursement (MAR) as established by Labor Code 413.011 was not figured correctly on the above services."

Amount in Dispute: $18,092.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has discounted the procedures based on Medicare and Texas Guidelines. Given these rates deemed fair and reasonable under Division rules, the hospital's assertion that it is entitled to an additional amount is not credible."

Response Submitted by: Hartford Underwriters Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 4 through June 6, 2011	Outpatient Hospital Services	$18,092.82	$17,825.19

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 10, 2012
   - W1 – WORKERS COMPENSATION SATE FEE SCHEDULE ADJUSTMENT. PAYMENT OF SERVICES

ARE INCLUDED IN THE VISIT RATE.

- W1 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT. FOR QUESTIONS REGARDING THIS ADJUSTMENT, PLEASE CALL QMEDTRIX AT 1-800-833-1993.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. WHEN MEDICALLY NECESSARY, IMPLANTABLES & ORTHOTICS AND PROSTHETICS ARE REIMBURSED AT COST TO THE HOSPITAL PLUS 10% PER THE TEXAS ACUTE CARE INPATIENT HOSPITAL FEE GUIDELINE.
- 217 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY. REDUCED TO FAIR AND REASONABLE.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. THIS SERVICE IS RE-PRICED ACCORDING TO THE TX PHYSICIAN FEE SCHEDULE.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. MAR AMOUNT IS GREATER THAN THE CHARGE AS PER TEXAS HOSPITAL GUIDELINES.

Explanation of benefits dated April 9, 2012

- 18 – REIMBURSEMENT FOR PROCEDURE WAS WITHHELD DUE TO A PREVIOUS SUBMISSION
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PRICED ACCORDING TO THE STATE APC FEE SCHEDULE RATE.

Explanation of Benefits Dated May 4, 2012

- 217 – BASED ON PAYER REASONABLE & CUSTOMARY FEES. REIMBURSEMENT MADE BASED ON INS CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY. CHARGES DISCOUNTED PER REVIEW BY QMETRIX. PLS CALL QMETRIX @ 1-800-833-1993 FOR QUESTIONS.

Explanation of Benefits Dated May 31, 2012

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. REIMBURSEMENT FOR YOUR NO ADDITIONAL MONIES BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCORDING TO STATE FEE GUIDELINES OR RULES AND REGULATIONS.
- 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. REIMBURSEMENT BASED ON QMEDTRIX CORRECTION.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. What is the additional recommended payment for the implantable items in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $74,000.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are

publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code C1778 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
- Procedure code 36415, date of service October 5, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
- Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.33. 125% of this amount is $4.16
- Procedure code 85018 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.33. 125% of this amount is $4.16
- Procedure code 85014, date of service October 5, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.33. 125% of this amount is $4.16
- Procedure code 85018, date of service October 5, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.33. 125% of this amount is $4.16
- Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 71020 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 617; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $27.02. This amount multiplied by the annual wage index for this facility of 0.8978 yields an adjusted labor-related amount of $24.26. The non-labor related portion is 40% of the APC rate or $18.02. The sum of the labor and non-labor related amounts is $42.28. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $42.28. This amount multiplied by

130% yields a MAR of $54.96.

- Procedure code 63685 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0039, which, per OPPS Addendum A, has a payment rate of $14,743.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $8,846.15. This amount multiplied by the annual wage index for this facility of 0.8978 yields an adjusted labor-related amount of $7,942.07. The non-labor related portion is 40% of the APC rate or $5,897.43. The sum of the labor and non-labor related amounts is $13,839.50. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $13,839.50. This amount multiplied by 130% yields a MAR of $17,991.35.
- Procedure code 63650 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0040, which, per OPPS Addendum A, has a payment rate of $4,553.02. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,731.81. This amount multiplied by the annual wage index for this facility of 0.8978 yields an adjusted labor-related amount of $2,452.62. The non-labor related portion is 40% of the APC rate or $1,821.21. The sum of the labor and non-labor related amounts is $4,273.83. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $4,273.83. This amount multiplied by 130% yields a MAR of $5,555.98.
- Procedure code 63650 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0040, which, per OPPS Addendum A, has a payment rate of $4,553.02. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,731.81. This amount multiplied by the annual wage index for this facility of 0.8978 yields an adjusted labor-related amount of $2,452.62. The non-labor related portion is 40% of the APC rate or $1,821.21. The sum of the labor and non-labor related amounts is $4,273.83. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $4,273.83. This amount multiplied by 130% yields a MAR of $5,555.98.

Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include: .

- "LINEAR 8 CONTACT LEAD KIT 70 CM" as identified in the itemized statement and labeled on the invoice as "ENH ST LD KIT, SC-2218-70 " with a cost per unit of $1,500.00 at 2 units, for a total cost of $3,000.00;
- "PRECISION RECHRG PULSE GENERAT" as identified in the itemized statement and labeled on the invoice as "PRECISION IPG KIT DUAL ARRAY " with a cost per unit of $12,500.00;
- "PATIENT PROGRAMMER KIT" as identified in the itemized statement and labeled on the invoice as "PATIENT PROGRAMMER KIT" with a cost per unit of $700.00;
- "CHARGING KIT" as identified in the itemized statement and labeled on the invoice as "PRECISION CHARGES SYSTEM" with a cost per unit of $2,000.00;
- "CLIK ANCHOR" as identified in the itemized statement and labeled on the invoice as "NEXT GENERATION ANCHOR KIT" with a cost per unit of $300.00.

The total net invoice amount (exclusive of rebates and discounts) is $18,500.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,600.00. The total recommended reimbursement amount for the implantable items is $20,100.00.

4. The total allowable reimbursement for the services in dispute is $49,282.41. This amount less the amount previously paid by the insurance carrier of $31,457.22 leaves an amount due to the requestor of $17,825.19. This amount is recommended..

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $17,825.19.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to to remit to the requestor the amount of $17,825.19, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 24, 2013
Signature	Medical Fee Dispute Resolution Officer	Date
		April 24,2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.